A Decade of International Change in Abortion Law: 1967–1977

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Abstract: Modern thinking on abortion, reflected in recent legal developments around the world, has turned from concentration upon criminality in favor of female and family well-being. New laws enacted during the last decade are coming to focus upon conditions of health and social welfare of women and their existing families as indications for lawful termination of pregnancy. Regulations governing the delivery of services may be restrictive, however, so as to limit in practice access to means of safe, legal abortion made available in theory. Requirements may be imposed that only medical personnel with unduly high qualifications perform procedures, or that they be undertaken only in institutions meeting standards higher than similar health care requires. Approval procedures may be established involving second medical opinions or committees to monitor observance of the law, which may delay abortions and therefore increase their hazards. Parental and spousal consent requirements may exist in addition with the same effects, or to veto a pregnant female's request. Regulations may be employed more positively, however, to encourage contraceptive practice. A disappointment with legislative reform is that it may fail to improve circumstances if public resources are not applied to achieve the supply of services newly rendered legitimate, and illegal practice may persist. (Am. J. Public Health 68:637–644, 1978.)

The continuing debate in the United States concerning the provision and funding of abortion services is distinguishable from debates occurring in many other countries. In the United States, the decriminalization of medically conducted abortion under the 1973 Supreme Court decisions in *Roe v. Wade* and *Doe v. Bolton* has generated proposals for a constitutional amendment to subordinate the privacy and other interests given priority in those Court decisions to interests of the fetus. It has also led to withdrawal of federal funding of all but very few procedures as an alternate means of quantitative control. These movements to limit the availability of abortion services may be contrasted with movements in other countries, where the stimulus is to make services more widely available and, still in the relatively early stage, of seeking liberalization of prohibitive laws. This article surveys this general international movement, referring to selected instances of legal reform for illustration.

In the past decade,[1] at least 42 jurisdictions [a] have changed their abortion laws: 39 have extended the grounds for abortion, and three have narrowed them.[b] Justifications for abortion are not identical in these laws, but different countries have selected their particular details from within the following range of indications:

i) Risk to the life of the woman;
ii) Risk to the woman's physical or mental health from continuation of pregnancy, meaning risk beyond that normally associated with pregnancy (the therapeutic indication);
iii) Some degree of likely physical or mental impairment of a child if born (the eugenic indication);
iv) Pregnancy by rape or incest (the juridical indication);
v) The effect of childbirth upon the health and welfare of the woman's existing children and family (the social, sociomedical or socioeconomic indication);
vi) Jeopardy to the social position of the woman or her family;[c]
vii) Failure of a routinely employed contraceptive means;[d]
viii) Simple request.

At least eight jurisdictions[e] have broadened their laws to allow abortion simply on request during a specified period of pregnancy, usually the first trimester, and on specified

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[a] See Appendix for analysis and for legal references where not given in the text.

[b] Bulgaria, Czechoslovakia, and Hungary.

[c] See the Criminal Code of Cyprus, s. 169A (b).

[d] See The Medical Termination of Pregnancy Act, 1971, of India, Explanation II of s.3 (2).

[e] Austria, Denmark, East Germany, France, Singapore, Sweden, Tunisia, and the United States.

grounds thereafter. About 22 other jurisdictions[f] in the past ten years have enacted[g] new laws to allow abortion on extended grounds ranging from risk to physical or mental health to socioeconomic indications.

Eight other laws have changed their provisions more modestly since 1967, to permit abortion but only where there is a serious risk to the life or physical health of the woman or on eugenic or juridical indications.[h]

The experience of the majority of the 30 jurisdictions that have liberalized their laws in the past ten years to permit abortion—eight on request, 22 on extended grounds—shows that while legal reform has been taken as a first step, the second step of implementation has not always followed. In a number of these 30 jurisdictions with such liberalized laws, the rate and the toll of illegal abortion upon life and health have not significantly declined. The services made legal in theory have not been made available in practice. Legitimization of termination of pregnancy does not in itself compel administrative authorities controlling health resources to meet the existing demand for abortion, nor ensure availability of services at the earliest possible stage of pregnancy. Where such authorities fail to back up new law with adequate resources, the only visible change in the national scene is confined to the statute book. Without a commitment by government to meet the demand for abortion being newly channeled into the legal branch of practice, the illegal branch retains the numbers of its clientele, and safe abortion continues to be within the means only of the wealthy.

The implementation of these 30 liberalized laws is often legally or administratively restricted by provisions regulating the delivery of services. The following provisions for implementation of the liberalized laws show how such provisions may be in part responsible for limiting the availability of services and delaying their availability to a later stage of pregnancy:

- Performance by specified professionals (e.g. doctors, nurses, trained health and auxiliary personnel);
- Performance by specified institutions (e.g. approved hospitals or clinics, on an inpatient or outpatient basis);
- Approval Procedures (e.g. medical concurrence, such as by a second opinion or an abortion committee);
- Consent Requirements (e.g. parental or spousal consent).

Some jurisdictions, however, have moved to counteract the limitations on the availability of services at the earliest possible stage of pregnancy, and to enable abortion services to lead to increased contraceptive practice, by including the following provisions in their laws:

- Contraceptive Provisions;
- Early Termination Provisions.

Specified Professionals

Liberalized abortion laws range from not regulating who may undertake pregnancy termination procedures, through requiring that they be performed only by registered medical practitioners, to requiring that the practitioners should have additional specialty qualifications.

Singapore, India, Northern Territory of Australia, and Israel are the four jurisdictions that have changed their laws since 1967 to require, by statute, regulation, or rule, that registered medical practitioners have specialized qualifications beyond those of general practitioners. The Singapore Abortion Regulations, 1974, differentiate qualifications needed by doctors to do early abortions from those needed to do later abortions. A medical practitioner in private practice performing abortions up to the sixteenth week requires at least six months' experience in an obstetrics and gynecology unit of a Singapore Government Hospital or another hospital recognized by the Minister of Health and Home Affairs. For doctors in private practice doing medical terminations up to the twenty-fourth week, the 1974 Regulations [section 3(2)] require additional professional qualifications.

The Singapore law waives the prescribed qualifications, however, where the treatment consists solely of the use of drugs prescribed by a registered medical practitioner and does not, therefore, include any surgical operation or procedure.[2]

The Indian Medical Termination of Pregnancy Act, 1971 [section 2(d)] provides that a registered medical practitioner have "such experience or training in gynecology and obstetrics as may be prescribed by rules made under this Act." Rules made in 1975, changed in order to simplify rules of 1972, allow for a registered medical practitioner to qualify through on-the-spot training or through academic qualifications. The Australian Northern Territory and Israel require that the doctor performing the abortion be a gynecologist.

A number of contending arguments emerge from legislation confining procedures to medical practitioners, and to those of them having special qualifications. It may at first seem difficult to oppose concentrating abortion procedures exclusively in the hands of qualified physicians. Protection of the health of women is an interest of the highest individual and social priority. Emergency wards, and cemeteries, bear dismal testimony to the work of the unqualified. Equally, it is obvious that late abortion by surgery does more violence to delicate physiology and psyche than a procedure assisting routine menstruation, and compels the attendance of the most relevantly skilled physicians and advanced appliances.

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[f] That is, those in the Appendix other than are listed in footnotes (b) and (e) above, and (h), below (first sentence).

[g] Reform has been achieved in all but very few jurisdictions by legislative enactments. Reform by judicial decision, such as the monumental English decision of 1938 in *R. v. Bourne* and the 1973 decisions of the U.S. Supreme Court in *Roe v. Wade* and *Doe v. Bolton*, is exceptional.

[h] Argentina, Benin, Cameroon, Chile, El Salvador, Guatemala, Morocco, South Korea and United Arab Emirates.

Beyond jurisdictions that have undertaken legislative reform, the following now have or have had reform under active consideration, to extend or narrow the law: Australia (Federal Commission), Bangladesh, Barbados, Belgium, Botswana, Canada, Ghana, Italy, New Zealand, Nepal, Netherlands, Nigeria, Pakistan, South Africa, South Korea, St. Vincent, Switzerland, Thailand, United Kingdom, and the United States (at state level, subject to federal adjudication).

The argument finds support in the practice of conscientious physicians referring late and potentially complicated cases to appropriately equipped facilities.

The argument in favor of ensuring high standards is compelling, especially since adverse reactions to routine procedures may in principle arise from any individual case. Nevertheless, the argument can be overstated, and its emphasis upon excellence has been found both to condemn the merely good and to disregard the governing realities. If medical procedures were to require performance by only the most highly skilled, many fewer could be undertaken than in fact are, and skills would be more difficult if not impossible to develop. Childbirth itself, which in countries with liberalized abortion laws presents a greater hazard to female health than early pregnancy termination,[3] is not generally surrounded by special legal requirements of qualifications of medical attendants. Leading physicians delegate many procedures, for which they remain medically responsible, to their staffs. They advise, supervise, and are at hand, of course, for instance in the event of emergency, but do not attend in person.[4]

In both developed and developing regions of the world, properly trained midwives, public health nurses, and comparable health and auxiliary personnel can conduct procedures early in pregnancy under adequate supervision. An advantage of their involvement may be their ability to provide a higher quality of pre- and post-abortion care and counseling than a busy physician can offer, thereby securing better and perhaps more confidential overall patient management. They already play an important role in fertility control, including menstrual regulation to which the earliest abortion is analogous. Further, as research produces non-surgical abortifacients with controllable side-effects,[5] a physician's proximity to their employment can be reduced, and effective management can be projected along more extended lines of delegation. Legally restricting medical services to the most scarce and costly personnel may prejudice community services.

Moreover, in countries where qualified physicians are in inadequate supply, or are unevenly distributed, many procedures have to be undertaken by health and auxiliary personnel. The alternative is the unavailability of such procedures to those unable to acquire privileged treatment, such as by purchase. Artificially high standards for delivery of health care appear unrealistic and indefensible in the creation of an abortion service intended to relieve hazardous or oppressive pregnancy that a given society has decided may legitimately be terminated.[6]

Specified Institutions

Law changes during the past decade have tended either to restrict the provision of abortion services to specified institutions, or to leave such directions to the discretion of the health professions. The abortion law in Denmark, for example, restricts services to those provided "only . . . in a state or communal hospital or a clinic (ambulatorium) attached to the hospital" [Chap. 3, section 10(1)]. Countries which have liberalized their laws by judicial decisions[(i)] do not so restrict services, but rather leave such determinations to the "good faith" of the registered medical practitioner, which may be evidenced by his use of facilities of a public institution.

Differences between standards required of facilities undertaking outpatient and inpatient services are becoming important as technology advances and barriers to early and prompt abortion are removed. Liberalized laws seem not expressly to deal with these differences, however, but relegate the function of specification of standards to subordinate regulations or rules. These provisions appear to be based upon consultations between legal and health personnel, and embody the detailed accommodation of needs to resources that comprises the discipline of hospital administration. Insofar as they simply embody current institutional practice, their expression in legal form does not control it; insofar as they vary from practice, they either restrict hospital and other services which physicians are prepared to undertake, or render services of questionable legality.

Experience discloses that the complex authorizing mechanisms with which countries such as Singapore and Britain initiated liberalized abortion laws, have been progressively simplified. Singapore has excluded medical termination by use of drugs alone from its locational requirements. The British Department of Health and Social Security has authorized termination of pregnancies of under 12 weeks' duration in day-care abortion centers.

The argument that has favored detailed supervision is that it promotes a high quality of care, and reduces or accomodates emergencies. Similarly, it may be required in late, surgical abortion when a viable fetus may be produced. The contending arguments are that closely drafted regulations over-intensify administrative and penal concerns irrationally; early abortion is shown to be safer than normal childbirth,[3] management of which is not hedged around with such provisions. Medical procedures other than for abortion are not so governed, and it may be appropriate to trust the clinical judgment and resource allocation of the medical profession in conducting abortion procedures no less than in conducting others.

Approval Procedures

Approval procedures vary from not specifically requiring the approval of anyone other than the requesting woman and the practicing professional (e.g. in Tunisia), to requiring the second opinion of a doctor (e.g. in Britain), or the approval of a board (e.g. in Canada). Some jurisdictions such as India and East Germany require approval only after a specified time period, usually the first trimester. Still others require different approval mechanisms for different indications for abortion; for instance, Iceland requires the approval of a physician and a social counselor for social in-

[(i)] See, for instance, Victoria (Australia) following *R. v. Davidson* (1969), and footnote (g), above.

dications, and the approval of a physician and psychiatrist for a mental health indication.

Most approval procedures can be waived under abortion laws in cases of emergency, but most laws do not explicitly permit appeals from approval procedures in routine cases. Denmark and Israel seem to be the only two countries whose abortion laws contain an appeal mechanism for applicants who have sought approval unsuccessfully.

The reason abortion legislation requires an approval procedure is to authenticate that abortion is performed only on a legal indication; the fact that the particular indication approved is usually not required to be agreed between the two or more opinions suggests that the procedure is not really aimed at improving health care. This is supported by the concentration of second opinions upon legal indications, and their disregard of the techniques proposed to be used; these can affect female health considerably, and selection of a suitable technique is a matter that physicians with responsibility for a patient's welfare might need to discuss. The second opinion may be given as a matter of routine, moreover, based upon reading existing records and reports, and the woman's condition may not really be independently assessed.

Further problems arise with a committee system, the abolition of which in Singapore after five years' experience may be instructive. Committee references reduce privacy, and can be unduly humiliating and degrading in a field where many women are routinely shy, not just because of embarrassing origins of their pregnancy. Committee approval, in common with other second opinion provisions, may also increase the cost of medical termination; few laws govern the fees which may be charged for that opinion. The incentive to earn fees may be medically distorting, it has been noted, in that a doctor requested to offer a second opinion to a physician favoring abortion, and therefore seeking the second opinion, may favor abortion to encourage the referring doctor to seek subsequent opinions from him in other cases.

Members of a hospital's therapeutic abortion committee may see their role as fastidiously to screen applicants on medical, psychiatric, and legal grounds, in order to safeguard the hospital, its medical and auxiliary staff, and themselves from the risk of liability to up to life imprisonment (for instance in Canada) for participating in an illegal abortion. As against this, however, some committees rarely meet together, but approve applications by telephone and correspondence as a matter of course, subject only to keeping within their facility's periodic quota of surgical time and hospital beds that can be devoted to the procedure.

This is clear from the Canadian experience, which also shows that committee approval procedures can be the most predominant reason for delay. Canadian abortion law provides for specially composed therapeutic abortion committees to consider abortion applications to decide whether "the continuation of the pregnancy . . . would or would be likely to endanger [the woman's] life or health" [section 251 (4)(c), Criminal Code].

The Badgley Committee [(j)] was established "to conduct a study to determine whether the procedure provided in the [Canadian] Criminal Code for obtaining therapeutic abortions is operating equitably across Canada." The Committee found that it was not, and the data accumulated provide material for instruction and warning to jurisdictions about to institute a liberalized abortion law with a committee approval procedure.

It is uniformly recognized that the earliest abortion is the safest, and the Badgley Committee favored making abortion available at the earliest stage possible. It was found, however, that on average, women take 2.8 weeks after first suspecting pregnancy (not just after actually becoming pregnant) to visit a physician, and that after this the average interval is eight weeks until the abortion is induced. The eight-week average is ominous in light of some committees' "rubber stamp" approach. The delay results from the manner in which physicians, hospitals, and therapeutic abortion committees often interact among themselves to evaluate their increasingly desperate and frustrated applicants. The Badgley Committee found that:

> ". . . many patients get the medical 'merry-go-round' treatment. This sequence of events is costly to the public purse, heightens the level of stress among patients, and extends the length of their pregnancies for many women."[7] (p. 19).

Consent Requirements

Few abortion laws mention consent, although one or two state in terms what is evident without expression, that the woman involved must consent to performance of the procedure upon her. The abortion laws that do mention consent require either parental or spousal consent.

As regards parental consent, the French law, for example, says "if the person is an unmarried minor, parental or guardian consent is necessary," leaving the determination of minority age to medical law or to family law. The Indian law, on the other hand, specifically requires consent for those women under the age of 18.

While abortion laws as such do not usually require parental consent, most legal systems contain such consent requirements under general law on age of majority and, if different, regarding consent to medical procedures or just to surgery. Where age consent requirements exist, ages vary from the traditional age of majority of 21, down to the age of independent consent to surgery in the Canadian province of Quebec of 14 years. Many legal systems also take into account concurrent Common law or customary doctrines of the "mature minor" and "emancipated minor",[8] to recognize autonomy in those under age who in fact take decisions affecting their own circumstances, for instance when they live alone, are self-supporting or married.

Hospital or medical by-laws or informal requirements

[(j)] Committee on the Operation of the Abortion Law, issuing Report, Ottawa, 1977.[7]

may also impose a condition of parental consent. This barrier to lawful termination of pregnancy following a medical finding of justification of the procedure may afford the parents disposal not only of their child's health, but of her educational and social future. This is the more oppressive in jurisdictions where the age of majority is relatively high, such as 21 years.

Abortion laws generally do not require spousal consent to an operation. The only exception seems to be the South Korean Maternal and Child Health Law, regulating abortion. The Icelandic law does not require spousal consent as a matter of law, but encourages the partner's involvement as a matter of practice by providing that:

> "where possible, the man shall make the application jointly with the woman, unless special circumstances render this inadvisable" [Chap. II, section 13 (4)].

Since the most common reason for an abortion procedure being advised is to serve the woman's health, the husband's or biological father's veto may appear to have no place. Nevertheless, perhaps as an exercise in defensive hospital practice, a number of clinics and institutions require husbands' or biological fathers' consent to procedures.

Contraceptive Provisions

Legislation inspired by the quest for social justice, aiming to afford the poor equal rights to health care, including safe medical procedures to terminate pregnancy, may be part of a program extending beyond the mere enactment of legislation; indeed, legislation may be not the end of the program, but the beginning. Abortion in some countries is not governed by the Criminal Code or comparable enactments, and is not the central focus of legislation, but is a residual part of a fertility control program giving priority to family life education and instruction in contraceptive means.

In this spirit, the 1975 Icelandic law is appropriately called the Law on Counselling and Education Concerning Sex and Childbirth and on Termination of Pregnancy and Sterilization. Similarly, the 1973 South Korean law regulating abortion and other matters of maternal health is called the Maternal and Child Health Law.

Legislation can encourage increased recourse to contraception by categorizing contraceptive failure as an indication for abortion. The Indian Law of 1971 acts as a contraception fail-safe in this way, guaranteeing that even the irreducible minimum risk of failure of a means of contraception need not result in childbirth. Laws can also enhance the right literally to plan one's family by providing, as does East German law, that:

> "In addition to the existing possibilities of contraception, a woman shall have the right to decide on the interruption of her pregnancy on her own responsibility, so as to be able to control the number, time and spacing of births." [Law of 9 March, 1972, section 1 (1)].

Some laws specifically require the provision of contraceptive advice and services to women in the post-abortion phase (e.g. in Finland). Further, Iceland requires that womens' partners be given contraceptive advice, its law providing that:

> "where the woman is married or cohabiting, the man shall, if possible, likewise be given instructions regarding contraception" [Chap. II, section 16].

Early Termination Provisions

While legislation cannot itself guarantee the supply of resources, it is in some cases designed to facilitate and encourage more equitably available provision, and to serve female health by favoring speedy abortion decisions so that procedures can be performed at the earliest possible time. For example, the abortion law in Finland has expressly enacted that:

> "Abortion must be performed at the earliest possible stage of pregnancy" [section 5].

The Finnish law also places a duty on the State Medical Board to ensure availability of services, by stating that:

> "The State Medical Board shall take measures to ensure that there are a sufficient number of physicians with authority to render opinions, and a sufficient number of abortion hospitals, in all parts of the country, and that physicians with authority to render opinions and operating physicians make every effort to adopt an impartial and consistent approach" [section 11].

Conclusion

General patterns of legal development show steady decriminalization of the practice of abortion. More broadly expressed indications for lawful procedures emphasize this trend, but even in jurisdictions where legal change has not occurred, criminal enforcement of prohibitive law is infrequent and selective [k]. The unqualified practitioner may very occasionally suffer prosecution, but the charge is likely to be manslaughter rather than just illegal abortion, or furnishing means to procure miscarriage. Awareness of the cost to female life and health of unqualified interference in pregnancy, and of the cost to public hospital, health, and welfare resources of its consequences, is on occasion a strong contributory cause of legal reform.

Many causes seem to have contributed, however, to the general movement to reform. Some may be cultural; it is noticeable, for instance, that the Scandinavian countries seem to have developed their laws interactively. Similarly, the so-

[k] Indeed in the Report of the Royal Commission of Inquiry named *Contraception, Sterilization and Abortion in New Zealand*, Wellington, 1977, the Commissioners observed that "Because of our inability to determine whether an operation performed by a medical practitioner in a hospital or surgery is legal or otherwise, we propose to confine our definition of an 'illegal' abortion to one which is performed by a non-medical person outside a hospital" (p. 153).

cial and political movement by women urging their unique group interests can be seen at a number of points to have applied pressure to ease legal restrictions upon all means of fertility regulation. Domestic population pressures and growing urbanization, and their disruptive effects upon traditional family life, exert influences upon family policy, and upon whether a pregnancy is wanted and bearable.

A further source of reform, whose influence cannot be measured, is that national health program leaders, at the administrative level rather than the political, often have studied in schools of public health and health administration in countries with less prohibitive laws, and with colleagues regarding abortion as a necessary even if regrettable health service.

This attitude may indeed be taken to characterize the last decade, which has seen abortion begin to move away from conceptualization within the realm of criminal law toward the field of welfare, which includes different forms of fertility regulation. The use of law to direct public resources to family welfare, and to encourage individuals to take their own preventive and protective initiatives in health, has promoted a vision of law in family health incompatible with crime and punishment. Unqualified medical practice is punishable at law in any event, so that the need for special criminal abortion laws is reduced. The growth of health and welfare laws has shown signs of refocusing perspectives on abortion. The practice is acquiring a lower profile in the health care setting of many jurisdictions, where it is coming to be treated in much the same manner as other comparable medical procedures.

Legal reform may deceive, however, since jurisdictions persuaded to change their laws do not necessarily undertake provision of services from public funds. The struggle in the United States over federal funding of services brings home a dichotomy between permission and support not uncommonly experienced. Legislative change often presents only a move from public prohibition unenforced by judicial proceedings, to public permission not supported by administrative resources.

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Authors' Post Script: In May 1978, Italy changed its abortion law to allow women, aged 18 years or over, to decide whether or not to have an abortion, if it is done during the first three months of pregnancy for physical or mental health or fetal indications, unlawful intercourse, or socioeconomic or family conditions. After the first three months, abortion is permitted, however, only when there is serious danger to the woman's life or risk of significant fetal malformation. Abortion is permitted for women under age 18 if their parents or guardians consent; if parental or guardian consultation is inadvisable, a judge can make a decision based on the doctor's report and the young woman's wishes.

APPENDIX

A Decade of International Change in Abortion Law: 1967-1977* Legal Indications for Abortion

Country KEY: × Law in 1967 ⊗ New Law / Repealed Law	Risk to Life of Woman	Risk to Her Physical Health	Risk to Her Mental Health	Risk to Health of Fetus	Unwanted Pregnancy by Rape or Incest	Social, Socio-Medical or Socio-Economic	On Request (usually First Trimester)**	Statutes and Cases in Force and Year of Latest Enactment or Decision
Argentina	⊗	⊗			⊗			1967 (6 Dec.) Penal Code, Sec. 8
Australia								
Capital Territory	×	⊗	⊗					1971 *R. v Wald*, Crimes Act Sec. 82-4
New South Wales	×	⊗	⊗					1971 *R. v Wald*, Crimes Act Sec. 82-4
Northern Territory	×	⊗	⊗	⊗				1973 Criminal Law Consolidation Ordinance, Sec. 79A.
South Australia	×	⊗	⊗	⊗		⊗		1969 Criminal Law Consolidation Amendment Act, Sec. 82A.
Victoria	×	⊗	⊗					1969 *R. v Davidson*, Crimes Act, Sec. 10, 65-66.
Austria	×	⊗	⊗	⊗			⊗	1974 (23 Jan) Federal Law
Benin	⊗							1973 (8 Feb) Ordinance No. 73-14 Code on Medical Deontology
Bulgaria	×	×	/	×	×	/	/	1974 Amendments & Additions Ministry of Health Regulations (1973)
Cameroon	⊗	⊗			⊗			1967 (12 June) Penal Code, Sec. 339
Canada	×	⊗	⊗					1975 *R. v Morgentaler*, Criminal Code, Sec. 251 (1969)
Chile	×	⊗						1967 (11 Dec) Sanitary Code Sec. 119
Cyprus	×	⊗	⊗	⊗	⊗	⊗		1974 Criminal Code, Sec. 169A
Czechoslovakia	×	×	/		×	/		1973 (16 May) Decree numbers 69, 70, 71
Denmark	×	×	×	×	×	×	⊗	1973 Law number 350
East Germany	×	×	×	×		×	⊗	1972 (9 March) Law on Pregnancy Interruption
El Salvador	⊗			⊗	⊗			1973 Penal Code cap 2, Art. 169
Fiji	×	⊗	⊗					1976 *R. v Emberson*, Penal Code cap 11 Sec 165-7, sec 265.
Finland	×	×	×	×	×	⊗		1970 (24 March) Law Number 239
France	×	⊗	⊗	⊗			⊗	1975 Law Number 75-17
Guatemala	⊗							1973 Penal Code Art 133-40
Hong Kong	×	⊗	⊗			⊗		1976 Offences Against the Person Amendment Ordinance
Hungary	×	×	/	×	×	/	/	1973 Resolution number 1040 of Council of Ministers 1973 Ordinance number 4 Minister of Health
Iceland	×	×	×	⊗	⊗	⊗		1975 (22 May) Law on Counselling & Education concerning sex and child-birth and on Termination of pregnancy and sterilization
India	×	⊗	⊗	⊗	⊗	⊗		1971 Medical Termination of Pregnancy Act
Iran	×	⊗	⊗	⊗		⊗		1976 (28 Oct) Civil Penal Code on Abortion and Sterilization, Art. 42, Sec. 3

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Israel	×	⊗	⊗	⊗	⊗	⊗		1977 (31 Jan) Penal Law Amendment (Interruption of Pregnancy)
Morocco	⊗	⊗						1967 (1 July) Crown Decree
New Zealand	×	⊗	⊗					1977 Contraception Sterilization and Abortion Act 1976 *R. v Woolnough*
Norway	×	×	×	×	×	⊗		1975 (13 June) Act number 50
Peru	⊗	⊗	⊗					1969 (18 March) Sanitary Code, Art. 19-23 1974 Abortion Act
Singapore	×	⊗	⊗	⊗	⊗	⊗	⊗	1975 Abortion and Sterilization Act number 2
South Africa	×	⊗	⊗	⊗	⊗			
South Korea	⊗	⊗		⊗	⊗			1973 (10 May), Maternal and Child Health Law
Sweden	×	×	×	×	×	×	⊗	1974 (14 June) Abortion Law (No. 595)
Tunisia	×	×	×	⊗	⊗	⊗	⊗	1973 Penal Code Art. 214 as amended
United Arab Emirates	⊗							1975 Federal Law number 7 on the Practice of Medicine
United Kingdom (excluding Northern Ireland)	×	×	×	⊗		⊗		1967 Abortion Act
United States***	⊗	⊗	⊗	⊗	⊗	⊗	⊗	1973 *Roe v Wade* 1973 *Doe v Bolton*
West Germany	×	×	⊗	⊗	⊗	⊗		1976 (18 May) Law 15, Fed. Const. Ct. decision of 25 Feb., 1975
Yugoslavia	×	×	×	×	×	⊗		1969 April 26 Decree on Pregnancy Termination
Zambia	×	⊗	⊗	⊗		⊗		1972 Act number 26.

Addendum: Rhodesia changed its law to permit abortion for physical health, fetal indications, and reasons of unlawful intercourse (Rhodesian Government Gazette, Dec. 9, 1977). Liberia changed its law to permit abortion for physical and mental health, fetal indications, and reasons of unlawful intercourse (law approved July 1976, not yet published in Gazette, i.e., not yet proclaimed in force).

*This chart is based on "Ten years of change in Abortion law 1967-76" prepared by Rececca J. Cook for *People*, Vol. 4, No. 1 International Planned Parenthood Federation.

This chart only covers actual changes in the law by enactment or court rulings—not administrative regulations—during the period 1967-1977.

All symbols indicate the grounds for abortion applying to all women, regardless of marital status or number of children.

Where the law has changed several times before and during the decade, the law change immediately previous to 1967 and the most recently enacted law are used for comparison.

Since this chart can only show in a general way the changes in laws on abortion, it is suggested that for more information on specific grounds, as well as information on where abortions must be performed, who they must be performed by, with what approval procedures, at what price and at what duration of pregnancy, readers should consult actual laws or, in appropriate cases, the International Digest of Health Legislation (World Health Organization) and Survey of Abortion Laws, by International Advisory Committee on Law and Population, Law and Population Program, Fletcher School of Law and Diplomacy, Tufts University, forthcoming.

It is hoped that information given in this chart is comprehensive and exact but, in view of problems of documentation and interpretation of new laws, the authors would welcome any corrections.

**Where the law permits abortion on request, usually during the first trimester, symbols also mark grounds on which abortion is permitted in subsequent trimesters.

***Where the law formerly differed by state but is now applicable to all states, i.e. the United States, the states with the narrowest laws are used for comparison with the 1973 U.S. Supreme Court decisions on abortion.